Determinants of depressive symptoms in Jordanian working women

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Accessible summary

- Depressive symptoms are a widespread medical problem affecting women worldwide, and Jordanian women in specific. In this study, depressive symptoms increased as a result of spousal abuse and diagnosis with chronic illnesses.
- Other factors could have contributed to the high prevalence rate of depressive symptoms in Jordanian working women. These factors include full-time job, responsibilities at home, social obligations to the family, and financial hardship.
- Women may not be aware of behaviours associated with depressive symptoms. They also may not consider such complaints as significant problems that necessitate seeking medical advice. Therefore, their complaints may get worse because of lack of medical assistance.
- Depressive symptoms and their determinants need to be screened in women. This can be done through routine assessment in health-care facilities.

Abstract

Depressive symptoms are an epidemic problem affecting different subgroups of women in clinical and non-clinical settings. However, depressive symptoms experienced by working women have rarely been studied. This study aimed at identifying depressive symptoms and their determinants in a sample of 101 Jordanian working women recruited from a higher educational institution. Data about women’s depressive symptoms, their educational level, presence of children, sharing a job with an intimate partner, health status, diagnosis with chronic illnesses, and complaints of spousal abuse were collected. Logistic regression analysis was used to test for the significance of the selected factors on women’s experiences of depressive symptoms. Findings indicated that 51.2% (n = 42) women complained of moderate and severe levels of depressive symptoms. Factors identified as significant in predicting depressive symptoms were women’s experiences of spousal abuse (odds ratio adjusted = 3.5, 95% confidence interval = 1.05–11.7) and being diagnosed with chronic illnesses (odds ratio adjusted = 7.09, 95% confidence interval = 1.2–42.2). It was concluded that causes of women’s depressive symptoms were imbedded in their familial and social environment, rather than their job per se. Mental health nurses can change the practice of nursing to better standards. Being familiarized with causes of depressive symptoms can empower nurses to be active advocates for depressed women.
Introduction

Depressive symptoms are a widespread medical and psychological problem. They are common in a wide range of communities with women being a highly vulnerable group (Weitzman 2004, Clemens et al. 2005). Depressive symptoms have contributed to functional impairments relevant to women’s physical health (Hegarty et al. 2004). They as well have extended to cause suicidal attempts (Thompson et al. 2002, Houry et al. 2005). Causes of depressive symptoms in women are many and include childhood abuse experiences (McGuigan & Middlemiss 2005, Al-Modallal et al. 2008b); witnessing family violence (Sox 2004); level of participation in religious activities (Helm et al. 2002); assumptions and beliefs of women such as self-control, self-worth and control of event’s outcomes (Harris & Valentiner 2002); and experiences of domestic violence (Csoboth et al. 2005, Mezey et al. 2005, Rayburn et al. 2005).

Depressive symptoms are an epidemiologic problem affecting multiple subgroups of women. Depressive symptoms were identified in women visiting emergency departments (EDs) (Houry et al. 2005), primary care clinics (Van Hook 1999), outpatient clinics (Diaz-Olavarrieta et al. 2002) and community dwellers (Yick et al. 2003). Yet, depressive symptoms are often unidentified unless women are asked directly or screened for such complaints. This could be related to the fact that depressive symptoms are highly subjective. Depressed individuals can experience a variety of highly subjective symptoms and exhibit behaviours that vary between them. Therefore, depression may go undiagnosed.

Working women are a considerable subset of community women and, yet, rarely screened for depressive symptoms. Consequently, their complaints of depressive symptoms, if any, are unknown. Few studies were identified investigating emotional problems in working women and most did not specify whether depressive symptoms were included. Swanberg and colleagues found that working women who had undergone some sort of abuse reported psychological influences described as emotional instability (Swanberg et al. 2006).

There are a substantial number of working women in Jordan. No studies were identified that examined Jordanian working women’s report of depressive symptoms. Determinants, or risk factors, of depressive symptoms in this critical subset of the community are unknown as well. This study was conducted to examine the magnitude of depressive symptoms among Jordanian working women and to identify the most significant determinants of depressive symptoms in these women. We hypothesized that certain occupational and familial factors contribute to this group’s complaints of depressive symptoms. These factors included women’s educational level, presence of children, sharing a job with the intimate partner, health status, diagnosis with chronic illnesses and complaints of spousal abuse.

Factors selected and included in the study as possible predictors for working women’s complaints of depressive symptoms were based on factors identified as issues within the Jordanian culture. Presence of children for married Jordanian women is a cornerstone in their lives. Sometimes, stability of the marital relationship is determined by presence of children as a result of marriage. Meeting children’s needs is a responsibility shared by the couple, yet women assume the greatest role. The responsibilities and stressors associated with raising children and concurrent work demands are of unknown impact on working women’s depressive symptoms. It is worth noting here that no studies were located examining this relationship in Jordanian women. General health status is a significant predictor for women’s complaints of depressive symptoms (Gallicchio et al. 2007). However, its effect on mental health status needs to be emphasized in working women.

Experiences of spousal abuse are possible risk factors for depressive symptoms. Spousal abuse significantly predicted depressive symptoms in different samples of women (Coker et al. 2002, Houry et al. 2006; Pico-Alfonso et al. 2006). However, this relationship needs to be fostered in working women. Brush (2003), on the other hand, reported a relationship between women’s employment and their exposure to spousal abuse. Simply stated, women’s employment predicted abuse and the latter predicted depressive symptoms. This study is specifically focused on working women. In this population, it would be valuable to identify whether another factor, such as working with the partner in the same institution, is a predictor of depressive symptoms.

Methods

Sample and procedure

Data for the study were collected from a higher educational institution in Jordan. Prior to data collection, approval for the study was obtained from the university administration. Women were included in the study only if they were married or engaged. Married or engaged women were recruited because part of the study looked at familial issues as possible determinants of depressive symptoms such as having children and experiences of spousal abuse. Women who had never been involved in an intimate relationship were excluded from the study.

To obtain a convenience sample of working women in the target educational institution, women working in academic and administrative positions were approached and
invited to participate in the study. Information about the study and its purpose was given. Those who agreed to participate were handed a questionnaire to complete. Anonymity of the participants and confidentiality of their information were sought by asking them not to write any identifying information, like their names, place of work or personal identification numbers, as part of the questionnaire. Women were asked to complete the questionnaire to the best of their knowledge. Return of the completed questionnaires constituted a response rate of 84%.

**Instrumentation**

Depressive symptoms were measured using the Center for Epidemiologic Studies-Depression (CES-D) Scale. It is a 20-item scale asking about the frequency of experiencing current (during the last week) depressive symptoms (Radloff 1977). Examples of the items include ‘I was bothered by things that usually do not bother me’ and ‘I had trouble keeping my mind on what I was doing’. Items were rated on a 4-point scale of 0 [rarely or none of the time (less than 1 day)] to 3 [most or all of the time (5–7 days)]. Four items were reverse-scored before calculating the total scale score. The final CES-D score ranges between 0 and 60, with higher scores indicating more symptoms. For the purpose of this study, dichotomous variable for the CES-D score was used. A cut-off point of 16, the standard cut-point, was used to identify those who do not complain of depressive symptoms (a total score of less than 16) and those who show evidence of depressive symptoms (a total score of 16 or higher) (Radloff 1977). The CES-D has good psychometric properties and was widely used in community samples (Andresen et al. 1994, McGuigan & Middlemiss 2005).

Spousal abuse was defined as a woman’s report of abuse perpetrated by her current or former male intimate partner (husband or fiancé). Lifetime experiences of spousal abuse were assessed. Spousal abuse was measured using items derived from a congressional report (United States General Accounting Office 1998). Examples of these items were whether women’s partners harassed them at work and whether women were prevented, by their partners, from working. Items of the congressional report were used in a previous investigation targeting working women (McFarlane et al. 2000). A modified version of these items was tested for its psychometric properties (Al-Modallal et al. 2008a). Responses for each item are dichotomized as either ‘Yes’ or ‘No’. A participant’s response as a ‘Yes’ for at least one item indicated exposure to spousal abuse.

Health status was measured using the Global Self-Rated Health. Respondents were asked to indicate how they rate their general health status. Responses were rated on a 5-point scale ranging from 1 = poor to 5 = excellent. The Global Self-Rated Health scale was used in a national health survey in the USA (Krause & Jay 1994) and was found effective in identifying factors determining health status in a Canadian survey (Cott et al. 1999).

Health status options were collapsed and dummy-coded. The ‘poor’ category was eliminated due to lack of responses. The ‘fair’ and ‘good’ categories were collapsed into one category (the ‘fair/good’ category) due to low frequency in the ‘fair’ category. The resulting three categories were dummy-coded where responses corresponding to the ‘very good’ health status were coded as ‘1’ and ‘0’ otherwise, and responses indicating ‘excellent’ health status were coded as ‘1’ and as ‘0’ otherwise. The ‘fair/good’ health status category was the reference group in the analyses.

Other factors hypothesized as having a relationship with women’s complaints of depressive symptoms were their report of chronic illnesses, women’s educational level, sharing the job with the spouse and presence of children. Those who reported a diagnosis with at least one chronic illness were coded as ‘1’ and those with no diagnosis of a chronic illness were coded as ‘0’. Chronic illnesses that women were asked about were: hypertension, diabetes, cancer, heart diseases, cholesterol and lipid problems, blood diseases, respiratory, gastrointestinal, kidney and liver diseases.

Women’s educational levels were categorized as some college, college degree or graduate degree. These variables were dummy-coded where those who had a college degree were coded as ‘1’ and ‘0’ otherwise and those who had a graduate degree were coded as ‘1’ and ‘0’ otherwise. The ‘some college’ group was the reference category in the analysis. Women’s indication that their spouses worked with them was coded as ‘1’ and ‘0’ otherwise and their indication that they had children was coded as ‘1’ and ‘0’ otherwise.

**Statistical analysis**

Descriptive statistics were used to present women’s demographic characteristics, complaints of depressive symptomatologies and the participants’ characteristics relevant to the variables under investigation. Logistic regression analysis was used to examine the significance of the selected factors in predicting women’s complaints of depressive symptoms. Results of logistic regression were presented using adjusted odds ratios (aOR) and the associated 95% confidence intervals (95% CI).

**Results**

One hundred and one women agreed to participate in the study. Participants were 25 years old and older with the
majority (80.7%) being between 25 and 35 years old. Eighty-six (86.9%) women were married and 13 were engaged, divorced or widowed. Educational level ranged from ‘some college’, reported by 20.2% of the women, to graduate level (master and doctorate), reported by over a quarter of the women (26.3%). Nearly two-thirds of the women had more than one child (70.7%). Only nine women reported that they work with their intimate partner/spouse at the same institution. The majority (56.5%) reported that the family income was less than Jordanian Dinar (JD) 700 a month (JD 1 = US $1.4).

Table 1 presents the demographic variables of the participants.

Forty-two women complained of depressive symptoms (51.2%); had a score of 16 or greater on the CES-D. The most common complaints reported by the women [rated at least ‘1’ [some or a little of the time (1–2 days)] on the 4-point scale of the CES-D] were ‘I had a feeling that people were unfriendly’, reported by 76% of the women and ‘I felt that everything I did was an effort’, reported by 75% of them. On the other hand, the least common complaints were women’s report that they were disliked by people and that their lives had been a failure. These complaints were reported by 28% and 30% of the women respectively.

With regard to selected variables hypothesized as having a relationship with women’s complaints of depressive symptoms, descriptive analysis for these variables showed that almost half (48.5%) of the women reported at least one experience of spousal abuse. Nearly a quarter (23.2%) of the women were diagnosed with one or more chronic illness; 17 were diagnosed with one disease and another five were diagnosed with two diseases. The most common chronic diseases were respiratory problems and gastrointestinal problems, reported by 11% and 10% of the participants respectively. That said, 93% of the participants described their health status as ‘excellent’, ‘very good’ or ‘good’, compared with 7% who described their health status as ‘fair’.

Logistic regression was then used to identify significant risk factors for women’s experiences of depressive symptoms. Logistic regression was done adjusting the analysis for women’s age, income, health insurance and spouse’s level of education. Women’s age has a reported relationship with women’s depressive symptoms (Hegarty et al. 2004, McGuigan & Middlemiss 2005, Wilke & Vinton 2005), and therefore, was controlled for. Income and possession of health insurance are somewhat related variables. These variables would affect women’s willingness to seek medical help for their depressive symptoms and, thereafter, were considered as confounders to the dependent variable. Finally, spouse’s educational level was controlled for to rule out possible interaction effect with women’s level of education on their depressive symptoms.

Results of logistic regression analysis, adjusting for possible confounders, revealed that women’s risk of depressive symptoms as a result of spousal abuse increased by over threefold compared with non-abused women (aOR = 3.5, 95% CI = 1.05–11.7), and the risk for those diagnosed with chronic illnesses increased by more than sevenfold (aOR = 7.09, 95% CI = 1.2–42.2). In addition, those who had college degree had lower risk of depressive symptoms, compared with those with lower academic degrees. Table 2 shows detailed information about the contribution of women’s occupational and familial factors to the risk of developing depressive symptoms.

Discussion

Given that working women may be at risk for developing depressive symptoms, we hypothesized that some familial and occupational factors including their educational level, presence of children, sharing a job with the intimate partner/spouse, health status, diagnosis with chronic illnesses and experiences of spousal abuse were significant determinants for their complaints. Findings revealed that depressive symptoms were common among this sample of Jordanian working women. In addition, experiences of spousal abuse and diagnosis with chronic illnesses

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Frequency (n, %)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td></td>
</tr>
<tr>
<td>25–30</td>
<td>48 (48.5)</td>
</tr>
<tr>
<td>31–35</td>
<td>32 (32.2)</td>
</tr>
<tr>
<td>36–40</td>
<td>12 (12.1)</td>
</tr>
<tr>
<td>&gt;40</td>
<td>7 (7.1)</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>86 (86.9)</td>
</tr>
<tr>
<td>Engaged/divorced/widowed</td>
<td>13 (13.1)</td>
</tr>
<tr>
<td>Education</td>
<td></td>
</tr>
<tr>
<td>Some college</td>
<td>20 (20.2)</td>
</tr>
<tr>
<td>College</td>
<td>53 (53.5)</td>
</tr>
<tr>
<td>Graduate</td>
<td>26 (26.3)</td>
</tr>
<tr>
<td>Have children</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>70 (70.7)</td>
</tr>
<tr>
<td>No</td>
<td>29 (29.3)</td>
</tr>
<tr>
<td>Income*</td>
<td></td>
</tr>
<tr>
<td>≤JD 700</td>
<td>56 (56.5)</td>
</tr>
<tr>
<td>&gt;JD 701</td>
<td>43 (43.4)</td>
</tr>
<tr>
<td>Spouse works with the woman</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>9 (9.3)</td>
</tr>
<tr>
<td>No</td>
<td>88 (90.7)</td>
</tr>
<tr>
<td>Health insurance</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>93 (94.9)</td>
</tr>
<tr>
<td>No</td>
<td>5 (5.1)</td>
</tr>
</tbody>
</table>

*JD is Jordanian Dinar (Jordanian currency) and JD 1 = US $1.4.
were significant factors increasing the risk of depressive symptoms.

The prevalence rate of depressive symptoms among the participants was noticeably higher than what was reported in previous investigations (Peden et al. 2000, Poleshuck et al. 2006). The high prevalence rate of depressive symptoms in this study could be related to some factors relevant to working women. All the participants in the current study had full-time jobs, 87% were married, nearly two-thirds had children, and 56.5% had a monthly family income of JD 700 or less (JD 1 = US $1.4). Work-related demands associated with full-time job, responsibilities at home including house work, child care and social obligations to the family, in addition to possible financial hardship could be sources of stress for this group of women. In Jordanian culture, house work and child care are most commonly the responsibilities of women, whereas men take a fraction of this responsibility in few cases. In addition to long working hours (finishing work at 17.00 h everyday), working women become subjects to stressors as they work to meet their job obligations at the expense, sometimes, of their family needs (Wang et al. 2007). On daily bases, working women stay overwhelmed with the family responsibilities that they could not finish or accomplish when they had to get them finished; a situation that predicts poor self-rated health status (Winter et al. 2006), mental disorders (Wang et al. 2007), and, possibly, complaints of depressive symptoms, as well. Other studies supported the previous analysis that could apply to Jordanian culture. Related studies indicated that the relationship between women’s life stressors, such as time pressure associated with too many responsibilities, financial concerns and work-related stressors, with their depressive symptoms was significant (McGuigan & Middlemiss 2005, Bromberger et al. 2007).

In a previous investigation, women complaining of depressive symptoms sought help for their complaints from the family, friends and health professionals in medical clinics (Van Hook 1999). Generally, women may not be aware of the characteristics associated with psychological problems, such as depressive symptoms (Edge et al. 2004). Therefore, they may not seek help from families and friends. If they do, they also may not consider such complaints as significant problems that necessitate seeking medical advice. Consequently, women’s, and Jordanian women’s, complaints of depressive symptoms may stay a personal experience that is not shared with others and could get worse due to lack of medical assistance.

Findings of the study demonstrated the significance of the contribution of women’s experiences of spousal abuse to the risk of developing depressive symptoms. This finding was supported by studies targeting different subgroups of women (Slashinski et al. 2003, Nicolaidis et al. 2004, Forte et al. 2005, Pico-Alfonso et al. 2006). The prevalence rate of spousal abuse reported by women in this study was noticeably high (48.5%). However, it did not go beyond the findings of the WHO multicountry study on women’s health and their experiences of domestic violence where the prevalence of lifetime physical or sexual partner violence,

| Table 2 Risk of depressive symptoms related to selected variables |
|-----------------|-----------------|-----------------|-----------------|-----------------|
| Variable        | n in Strata | Depressed (n, %) | Unadjusted OR | 95% CI | Adjusted OR* | 95% CI |
| Spousal abuse   |             |                  |                |       |             |       |
| No              | 38          | 14 (36.8)       | 1.00           | REF   | 1.00        | REF   |
| Yes             | 42          | 26 (61.9)       | 2.79           | 1.13–6.90 | 3.5      | 1.05–11.7 |
| Health status   |             |                  |                |       |             |       |
| Fair/good       | 25          | 17 (68)         | 1.00           | REF   | 1.00        | REF   |
| Very good       | 43          | 20 (46.5)       | 0.67           | 0.28–1.61 | 0.88     | 0.27–2.9 |
| Excellent       | 14          | 5 (35.7)        | 0.47           | 0.14–1.53 | 0.51     | 0.10–2.47 |
| Education       |             |                  |                |       |             |       |
| Some college    | 19          | 12 (63.2)       | 1.00           | REF   | 1.00        | REF   |
| College         | 42          | 17 (40.5)       | 0.43           | 0.17–1.04 | 0.22     | 0.06–0.86 |
| Graduate        | 20          | 12 (60)         | 1.66           | 0.59–4.62 | 2.4      | 0.45–12.9 |
| Chronic illness |             |                  |                |       |             |       |
| No              | 62          | 27 (43.5)       | 1.00           | REF   | 1.00        | REF   |
| Yes             | 18          | 15 (83.3)       | 6.5            | 1.7–24.7 | 7.09     | 1.2–42.2 |
| Have children   |             |                  |                |       |             |       |
| No              | 24          | 11 (45.8)       | 1.00           | REF   | 1.00        | REF   |
| Yes             | 57          | 30 (52.6)       | 1.3            | 0.51–3.4 | 1.94     | 0.46–8.25 |
| Spouse works with the woman | |                  |                |       |             |       |
| No              | 73          | 38 (52.1)       | 1.00           | REF   | 1.00        | REF   |
| Yes             | 7           | 3 (42.9)        | 0.69           | 0.14–3.31 | 0.68     | 0.08–5.43 |

*Adjusted for women’s age, monthly income, possession of health insurance, and spouse’s education. CI, confidence intervals; OR, odds ratios.
or both among women from 10 different countries ranged between 15% and 71% (Garcia-Moreno et al. 2006).

The status of women in Jordan has gone through a significant transition in terms of achieving a number of women’s rights. Examples of women’s achievements are their right to an education, benefit from health services, voting, and their political and legal contributions in the country. Despite these achievements, some women still suffer some gender-based issues such as spousal abuse. This problem is obvious in this study evidenced by the reported prevalence of spousal abuse indicated by the participants. In response to this problem in Jordan, a number of legislative decrees were issued to protect women against spousal abuse. In addition, several governmental contributors, such as the National Council for Family Protection (NCFP) and Dar Al-Wifaq centre, are putting their efforts together to fight for women’s right and to protect them from abuse perpetrated by the partner. These efforts have increased women’s awareness about spousal abuse. This awareness is seen in women’s disclosure of abuse to families, legal system and media. Although the step of disclosure is still in its early stages, it is a huge transition in a culture such as Jordan.

Women’s complaints of spousal abuse and its relationship with their depressive symptoms are significant and worth noting. Working women with experiences of spousal abuse are at risk of losing time from work due to a lack of focus and attention at work and an inability to accomplish job-related tasks (Swanberg & Macke 2006, Swanberg et al. 2006). As a result, being subjected to spousal abuse and concurrent complaints of depressive symptoms may cause women lose more time from the job. Consequently, the overall job performance level of the institution is affected. This conclusion is critical as women in this study were recruited from a higher educational institution aiming at providing high-quality knowledge and services to a large number of students in different fields and specialties. In other words, women’s complaints of depressive symptoms as a result of spousal abuse can affect the quality of services provided by such institutions. Connecting women’s experiences of spousal abuse and depression with their job performance is a possible, reasonable relationship. Unfortunately, current data do not have evidence to support this speculation. Therefore, further investigations including qualitative data describing this relationship would provide support for this assumption.

The predictive relationship between chronic diseases and depressive symptoms found in this study was congruent with findings of a recent study where women diagnosed with chronic obstructive pulmonary disease, bronchial asthma and tuberculosis were more prone to developing depression and anxiety, compared with men (Moussas et al. 2008). This relationship could be explained by understanding negative health consequences associated with chronic diseases. Chronic diseases are often associated with physiological changes and disabilities. Such disabilities prohibit women from meeting home and family demands, job demands, and even personal needs. In addition, women’s need to cope with the chronic disease bears further stressors beyond the disabilities associated with the disease itself. Cumulatively, inability to meet family and work demands relevant to disabilities associated with chronic diseases may contribute to working women’s complaints of depressive symptoms.

The association between women’s diagnosis of chronic diseases and their depressive symptoms can be explained in light of the significance of spousal abuse in different aspects of women’s lives. Some investigators indicated that spousal abuse is a significant contributor for women’s complaints of chronic diseases (Coker et al. 2002, 2005). A variety of findings, on the other hand, pointed to the significance of spousal abuse in developing depressive symptoms (Weingourt et al. 2001, Dutton et al. 2005; Zink et al. 2005). Put differently, diagnosis of chronic illnesses and complaints of depressive symptoms are two outcomes of women’s experiences of spousal abuse. Based on the findings discussed earlier, we can estimate an additive effect between spousal abuse and diagnosis of chronic illnesses that contributes to women’s development of depressive symptoms. This proposition was supported elsewhere (Forte et al. 2005).

Recommendations and implications

It has been found that causes of depressive symptoms in this sample were imbedded in their familial and social environment, rather than their job per se. To help women prevent complaints of depressive symptoms, it is important to help them identify symptoms of these complaints. Some women may not be aware of the seriousness of their condition unless they are told about it. In other words, it is possible that some women need to be informed about behaviours or symptoms attributable to some illnesses including psychological problems. Therefore, information about symptoms of psychological complaints, including depressive symptoms, could be distributed to women at the primary healthcare centres. Women need to be encouraged to see a health professional if they experience these symptoms.

As a result of the seriousness of spousal abuse in women’s lives in general, different mass media methods have started discussing the issue of spousal abuse more openly than before. This step has started educating women about this problem and providing them with ways to
protect themselves and their children. In order to foster the efforts done through mass media, it is recommended that information about spousal abuse including its causes, consequences, effects on children, safety plans for abused women and their children, and community resources are provided to working women wherever they are located.

The study concluded that depressive symptoms in this sample of working women were determined by their experiences of spousal abuse as well as their complaints of chronic illnesses. This finding has significant implications for mental health nurses. In nursing practice, mental health nurses have the opportunity to assess and diagnose symptoms of health problems, depressive symptoms, and experience of spousal abuse. Valid and reliable screening tools for depressive symptoms and spousal abuse are available. Nurses can integrate screening for mental health problems and some of their determinants, such as spousal abuse, in the routine assessment of women visiting various health care facilities.

Familiarizing mental health nurses with determinants of depressive symptoms can empower them to be change agents and advocates for depressed women. Based on their knowledge and skills, they can move the practice of mental health nursing to higher standards and enrich the literature with intervention studies. In addition, they can help abused women benefit from the rules and legislations that govern their dignity and safety; a practice that would improve mental health status of women.

Limitations

This study has a number of limitations. First, the sample size was relatively small. Second, work-related factors that could determine complaints of depressive symptoms were not included. These factors include career satisfaction, relationship with coworkers and type of relationships with supervisors. Third, family satisfaction factors like family responsibilities of each spouse, relationships with the husband’s family and women’s relationship with their own families were not included. For future studies, it is recommended that a larger sample size of women with a variety of characteristics recruited from different settings be studied. In addition, inclusions of more family- and work-related factors are needed to determine whether they affect working women’s mental health status.

References


